MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06093 Reg. Dist. No. 1-66

1. PLACE OF DEATH:
County: Garrett
City or town: McHenry, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: McHenry, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harland Bowser.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

9.(b) Name of husband or wife
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 2d, 1945.

8. AGE: Years	Months	Days	If less than one day
0	1	12	hrs. min.

9. Birthplace: McHenry, Md. (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Wilbur Bowser.
13. Birthplace: McHenry, Md.
MOTHER 14. Maiden name: Marie Simmons.
15. Birthplace: Crellin, Md.
19. Informant: Wilbur Bowser.
Address: McHenry, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17th/45 (month) (day) (year)
Cemetery or crematory: Thayerville Cemetery.
Location: Thayerville, Md.
19. Funeral director: Emory D. Bolden.
Address: Oakland, Md.
19. 6-16 19 45 Julia Roman Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th 19 45 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 14 19 45 to June 14th 19 45 and that I last saw him alive on June 14 19 45

Immediate cause of death: Double Lobar Pneumonia — DURATION: ?
Sans this child
Due to: in office but gave it no medicine. Gave it no medicine. Temp. was
Due to: 110 and it was in dying condition
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. F. Glenn M.D. M. D. or other
Address: Friendsville, Maryland Date signed: 6-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

06694

Reg. Diat. No. 162

1. PLACE OF DEATH:

County: Garett

City or town: R.D.2 Gra ntsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Garett

City or town: R.D.2 Grantsville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Devoir

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Katie Devoir

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Febuary 4 I870

8. AGE: Years	Months	Days	If less than one day
75	4	2	....hrs. ....min.

9. Birthplace: Hyndman Pa (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: RObert Devoir

13. Birthplace: Hyndman Pa

MOTHER — 14. Maiden name: Mary Devoir

15. Birthplace: Hyndman Pa

16. Informant: Mrs Grace Smith

Address: Meyersdale Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-8-I945 (month) (day) (year)

Cemetery or crematory: Grantsville

Location: Grantsville Md

18. Funeral director: Wm A Winterberg

Address: Grantsville Md

19. June 8 1945 Ethel Broadwater (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1945 at 1.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1944 to June 6 1945

and that I last saw h... alive on June 5 1945

	DURATION
Immediate cause of death: Bronchopneumonia	3 yrs
Due to:	
Due to:	
Other condition: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. R. Davis M.D. M. D. or other

Address: Grantsville Md Date signed June 8 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

06095

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:
County: GARRETT
City or town: GRANTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? THREE YEARS
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: GARRETT
City or town: GRANTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MATILDA FAILINGER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband ~~or wife~~: JOHN G. FAILINGER
DECEASED 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July - 27 - 1867

8. AGE: Years	Months	Days	If less than one day
77	10	6	..... hrs. ..... min.

9. Birthplace: COVE, GARRETT Co. MD. (Town, county, and state)
10. Usual occupation: HOUSE WIFE
11. Industry or business
FATHER 12. Name: WILLIAM HOCKMAN
13. Birthplace: GERMANY
MOTHER 14. Maiden name: LOUISA MILLER
15. Birthplace: PHILADELPHIA, PA.
16. Informant: WILLIAM H. FAILINGER
Address: GRANTSVILLE, MD
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JUNE 5 - 1945 (month) (day) (year)
Cemetery ~~or crematory~~: ADDISON Penna.
Location: ADDISON Penna.
18. Funeral director: WM. WINTERBERG
Address: GRANTSVILLE, MD.
19. June 4 1945 (Date rec'd by registrar) Ethel Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1945, at 9:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945, to June 3 1945
and that I last saw her alive on June 2 1945

Immediate cause of death	DURATION
Cerebral Hemmorhage	3 days
Due to	
Due to	
Other condition: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. R. Davis M.D. M. D. or other
Address: Grantsville md Date signed: June 3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06696

Reg. Dist. No. 164

1. PLACE OF DEATH:
County: Garett
City or town: Rural Near Addison Pa
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Rural Near Addison Pa
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Randy Cardon Gatterman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	-

6.(b) Name of husband or wife: --
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 6- I942

8. AGE: Years	Months	Days	If less than one day
2	6	I2	hrs. min.

9. Birthplace: Garett Co Md Rural N.Addison. Pa
(Town, county, and state)

10. Usual occupation: H

11. Industry or business

FATHER
12. Name: Victor Gattermon
13. Birthplace: R.D.I Grantsville Md

MOTHER
14. Maiden name: Erma Knopsnider
15. Birthplace: Marklysburg Pa

16. Informant: Victor Gatterman
Address: Addison Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-20-I945 (month) (day) (year)
Cemetery or crematory: Hetz
Location: R.D. Accident Md

18. Funeral director: Allen Winterberg
Address: Grantsville Md

19. June 19 19 45 (Date rec'd by registrar) Emmanuel Spoerlein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] after [illegible] 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture Skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 6/18/45
Where did injury occur? near Grantsville Garrett Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) On public road
Means of injury Fall out of truck Injured at work? No

23. SIGNATURE: E. I Baumgartner M.D. Dpty. Coro. Garr. Garrett Co.
M. D., or other
Address: Oakland Md Date signed 6/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

06097

CERTIFICATE OF DEATH

Reg. Dist. No. 164

1. PLACE OF DEATH:
County: Garett
City or town: Accident
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Accident Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clara Bell Haenftling

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Augest Haenftling
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 6-1889

8. AGE: Years	Months	Days	If less than one day
55	9	5	..... hrs. ..... min.

9. Birthplace: Near Friendsville Md (Town, county, and state)
10. Usual occupation: House work
11. Industry or business

FATHER
12. Name: Jermiah Bittner
13. Birthplace: Near Friendsville Md

MOTHER
14. Maiden name: Mary A. Bowman
15. Birthplace: ~~xxxxxx~~ Meyersdale Pa

16. Informant: Henry Haenftling
Address: Accident Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14-1945 (month) (day) (year)
Cemetery or crematory: German Lutheran
Location: Accident Md
18. Funeral director: Wm. Winterberg
Address: Grantsville Md

19. June 13 1945 (Date rec'd by registrar) Emmard Sperlein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945 at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 11 1945 and that I last saw h[illegible] alive on June 8 1945

Immediate cause of death	DURATION
Carcinoma of small intestines	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. R. Davis M.D.
M. D. or other
Address: Grantsville Md Date signed: June 12

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ 06098

Reg. Dist. No. 163

1. PLACE OF DEATH:

County: Garrett

City or town: Bloomington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Garrett

City or town: Bloomington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James Garland Howard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha O'Neil

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June 21, 1878

8. AGE: Years: 67 | Months: 0 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Winchester, Frederick, Va.
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Grocery Store

FATHER

12. Name: James W. Howard

13. Birthplace: Frederick, Md.

MOTHER

14. Maiden name: Virginia Brason

15. Birthplace: Virginia

16. Informant: Richard Howard

Address: Bloomington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 3 1945 (month) (day) (year)

Cemetery or crematory: Bloomington

Location: Bloomington

18. Funeral director: Mrs Lacy Beale Berry

Address: Westernport, Md.

19. July 3 1945 (Date rec'd by registrar) Dorsey Pattison Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30, 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945, to June 30 1945

and that I last saw him alive on June 29 1945

Immediate cause of death	DURATION
Carcinoma Prostate	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P E Berry M.D.

M. D. or other

Address: Piedmont, W. Va. Date signed: 7/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1 06699

Reg. Diat. No. 163

1. PLACE OF DEATH

County Garrett

City or town Bloomington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Garrett

City or town Bloomington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Maudie Katherine Santy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Cecil A. Santy

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1903

8. AGE: Years 42 | Months 3 | Days 15 | If less than one day ... hrs. ... min.

8. Birthplace Jamania-Grant-W.Va (Town, county, and state)

10. Usual occupation Home-wife

11. Industry or business Home

MOTHER FATHER

12. Name Alfred Helmick

13. Birthplace Hamilton W.Va

MOTHER

14. Maiden name Francis Flint

15. Birthplace Hamilton W.Va

16. Informant Cecil Santy

Address Bloomington Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6 1945 (month) (day) (year)

Cemetery or crematory Bloomington

Location Bloomington Md.

18. Funeral director Ellsworth S. Boaf

Address Westernport, Md.

19. 6-6 1945 Dorsey Pattison

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4/45 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/2/45 1945, to 6/4/45 1945

and that I last saw her alive on 6/2/45 1945

	DURATION
Immediate cause of death Lobar Pneumonia	1 wk ?
Due to Malnutrition	
Due to Chr. Myocarditis	
Due to Arteriosclerosis	
Other conditions Bed sore	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. W. Reeves M.D. M. D. or other

Address Westernport Md. Date signed 6/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

06101

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH:
County: Garrett
City or town: Rural- Swanton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29yrs.
Hospital, Institution, or Street address where death occurred: 1 mile East Wilson
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Rural- Swanton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1 Mile East Wilson
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Chlorice Wheeler Lee

3.(b) Social Security Number: 215-12-2084

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Betty Rosella (Moates) (Smith) Lee
6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): March 8, 1916

8. AGE: Years	Months	Days	If less than one day
29	3	16	hrs. min.

9. Birthplace: Swanton, Garrett Co., Md.
(Town, county, and state)
10. Usual occupation: Timberman
11. Industry or business: Saw mill

FATHER
12. Name: Jacob Roderick Lee
13. Birthplace: Garrett Co., Md.

MOTHER
14. Maiden name: Mae Lucinda Carder
15. Birthplace: Near Swanton, Md.

16. Informant: Mrs. Jacob R. Lee
Address: Swanton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 27 1945 (month) (day) (year)
Cemetery or crematory: Georg e Cemetery
Location: Swanton, Md.

18. Funeral director: Otha F. Sharpless
Address: Blaine, W.Va.

19. June 26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 19 45, at 10:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 45, to June 20 19 45
and that I last saw h[im] alive on June 20 19 45
Immediate cause of death: Dead at arrival — DURATION
Coronary Thrombosis
Due to: Auricular Fibrillation
Due to: Acute Rheumatic Fever
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ralph Calandrella M.D.
M. D. or other
Address: Lily Lee, MD Date signed: June 26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

06105

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:
County: Garett
City or town: Grantsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Grantsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alice Leidinger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Joseph Leidinger
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 22-1879

8. AGE: Years	Months	Days	If less than one day
65	5	13	..... hrs. ..... min.

9. Birthplace: R.D.1 Grantsville Md (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business
FATHER 12. Name: George W Miller
FATHER 13. Birthplace: R.D.1 Grantsville Md
MOTHER 14. Maiden name: Sara M.Crowe
MOTHER 15. Birthplace: R.D,2 Grantsville Md
16. Informant: Mrs Lizzie Durst
Address: Grantsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-7-1945 (month) (day) (year)
Cemetery or crematory: New Germany
Location: R.D.2 Grantsville Md
18. Funeral director
Address: Grantsville Md
19. June 6 1945 Ethel L Broadwater Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1945 at 5:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1944 to June 4 1945 and that I last saw h.. alive on June 4 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. R Davis M.D. M. D. Other
Address: Grantsville Md Date signed: June 5 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

06102

★ Reg. Dist. No. 166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Rural Oakland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 yrs.
Hospital, institution, or street address where death occurred: ---
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Rural Oakland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 10 Mi. N W Oakland, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: -----

3. (a) FULL NAME: Joseph Friend Lewis

3. (b) Social Security Number: -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth A. Lewis
6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1857

8. AGE: Years	Months	Days	If less than one day
87	9	1	....hrs. ....min.

9. Birthplace: Garrett Co., Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own Farm

FATHER
12. Name: John Phillip Lewis
13. Birthplace: Garrett Co., Md.

MOTHER
14. Maiden name: Anna Johnson
15. Birthplace: Garrett Co., Md.

16. Informant: Asa Lewis
Address: Oakland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 11, 1945 (month) (day) (year)
Cemetery or crematory: Lake Ford Church Cemetery
Location: 10 mi. N W Oakland, Md.
18. Funeral director: Herbert C. Leighton
Address: Oakland, Maryland

19. 6-10-45 (Date rec'd by registrar) Julia Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1945 19.... 5:10P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6-1-45 19.... to 6-8-45 19....
and that I last saw h... im alive on 6-7-45 19....

Immediate cause of death	DURATION
Bronchial Pneumonia	3 Weeks
Due to	
Due to	
Other conditions: Heart Weakness	4 days

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Edward E. Dorsey Jr. M. D. or other
Address: Oakland, Maryland. Date signed 6/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-L)

06103

CERTIFICATE OF DEATH

Reg. Dist. No. 16 7

1. PLACE OF DEATH:
County: Garrett
City or town: Friendsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
At home
How long in hospital or institution? 3 or 4 weeks once

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Friendsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Charles Pletcher

3.(b) Social Security Number: 0

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	no

6.(b) Name of husband or wife: none
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25 1881

8. AGE: Years	Months	Days	If less than one day
63	11	1	..... hrs. ..... min.

9. Birthplace: Normalville, Fayette Co., Penna. (Town, county, and state)
10. Usual occupation: Blind
11. Industry or business
FATHER 12. Name: David Pletcher
FATHER 13. Birthplace: Normalville, Fayette Co. Penna.
MOTHER 14. Maiden name: Jemima Grimm
MOTHER 15. Birthplace: Normalville, Fayette Co. Penna.
16. Informant: Mrs. C. M. Savage (Sister)
Address: Friendsville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 29-45 (month) (day) (year)
Cemetery or crematory: Blooming Rose Cem.
Location .....
18. Funeral director: E. G. Harned
Address: Brandonville W. Va.
19. 6-29-1945 (Date rec'd by registrar) Ira C. Rush Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 19 45 at 9:50 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1941 19 ..... to June 26 19 45 and that I last saw him alive on June 23 19 45

Immediate cause of death	DURATION
Generalized Carcinomatosis	?
Primary Carcinoma of stomach.	
Metastases in liver & ribs.	
Due to	
Other conditions: hypertension; myocardial damage; secondary anemia	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. F. Glover M.D. M. D. or other
Address: Friendsville, Maryland Date signed 6-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

06104

Reg. Dist. No. 166

1. PLACE OF DEATH:
County: Garrett
City or town: Mt. Lake Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Preston.
City or town: Aurora, W. Va.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mrs. Effie Feather Teets.

3. (b) Social Security Number: 7 0 -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward L. Teets.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 21st, 1869

8. AGE: Years	Months	Days	If less than one day
76	4	16	..... hrs. ..... min.

9. Birthplace: Albright, W. Va. (Town, county, and state)
10. Usual occupation: House wife.
11. Industry or business

FATHER
12. Name: Zachriah Feather.
13. Birthplace: Kingwood, W. Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

18. Informant: Mrs. Mildred Dunne.
Address: Frederick, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8th/45 (month) (day) (year)
Cemetery or crematory: Carmel Cemetery.
Location: Aurora, W. Va.

18. Funeral director: Emmert D. Baldeen.
Address: Oakland, Md.

19. 6-7-45 (Date rec'd by registrar) Julia Rayon, Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1945, at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945, to June 1945, and that I last saw h[illegible] alive on June 6 1945.

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Bronchial Asthma	
Due to:	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. L. Baumgartner M.D. M. D. or other
Address: Oakland, Md. Date signed 6/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

06105

★ Reg. Dist. No. 16 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Oakland
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: World War No. I

3.(a) FULL NAME: Max Henry Welling.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20th, 1888

8. AGE: Years	Months	Days	If less than one day
56	11	11	hrs. min.

9. Birthplace: Oakland, Maryland.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: David Welling.
13. Birthplace: Cameron, W. Va.

MOTHER
14. Maiden name: Nancy C. Kemphfer.
15. Birthplace: Rockingham, County, Va,

16. Informant: Mr. George Welling.
Address: Oakland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4th/45 (month) (day) (year)
Cemetery or crematory: Oakland Cemetery.
Location: Oakland, Maryland.

18. Funeral director: Emroy D. Bolden.
Address: Oakland, Maryland.

19. June 3- 19 45 (Date rec'd by registrar) Julia A. Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-1-45 19 at 9:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1-45 19 to 6-1-45 19 and that I last saw him alive on 6-1-45 19

Immediate cause of death	DURATION
Anginae Pectoris	3 hours
Due to	
Due to	
Other conditions: Heart attack	Sudden

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward E. Bolden M. D. or other
Address: Oakland. Maryland Date signed: 6-2-45